

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEVADA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

— Process for the Investigation of Allegations of Resident Neglect
and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

INTERAGENCY COMPLAINT PROCEDURE

State agency receives complaint from complaining party.

Complaint is logged and prioritized per agency protocol. If the complaint is Priority One, the Health Division is notified immediately and the Health Division will investigate or a joint investigation will be arranged.

Complaint is investigated using the agency's legal authority to investigate.

Facility is notified of deficiencies (if any) and request/demand is made for corrective action.

If corrective action is appropriate, coded complaint form along with documentation is forwarded to the Health Division for follow up.

Health Division logs completed complaint into the "Complaint Registry."

Complaints requiring Health Division follow up will be investigated based on the Health Division assigned priority. A copy of the "Statement of Deficiencies and Plan of Correction" will be forwarded to the originating agency upon completion of the investigation and response by the provider.

SEE ATTACHED PRIORITY SYSTEM, CODING AND COMPLAINT FORM.

TN No. 93-3
Supersedes
TN No. N/A

Approval Date May 5, 1993 Effective Date 1/1/93

08/15/91

INTER-AGENCY COMPLAINT PROCEDURE

1. Agency receives complaint from complaining party.
2. Complaint is logged and prioritized per agency protocol. If the complaint is Priority One the Health Division is notified immediately and the Health Division will investigate or a joint investigation will be arranged.
3. Complaint is investigated using the agency's legal authority to investigate.
4. Facility is notified of deficiencies (if any) and request/demand is made for corrective action.
5. If corrective action is appropriate, coded complaint form along with documentation is forwarded to the Health Division.
6. If corrective action is appropriate, coded complaint form along with documentation is forwarded to the Health Division for follow-up.
7. Health Division logs completed complaint into the 'Complaint Registry.'
8. Complaints requiring Health Division follow-up will be investigated based on the Health Division assigned priority. A copy of the "Statement of Deficiencies and Plan of Correction" will be forwarded to the originating agency upon completion of the investigation and response by the provider.

COMPLAINT PRIORITY SYSTEM

PRIORITY	DEFINITION
1	A Priority One complaint is one in which it appears that a life threatening situation exists or there is an "immediate and Serious Threat" to the health and safety of the patients or residents. Priority One complaints may be referred by telephone and followed in writing by the originating agency. Priority One complaint shall be referred to the Health Division immediately and investigated within 72 hours.
2	A Priority Two complaint is one in which no "Immediate and Serious Threat" exists, but there is situation where expeditious investigation could prevent harm or improve care delivery to patients or residents. Priority Two complaints are investigated by the Health Division within 14 days.
3	A Priority Three complaint is a complaint of a routine nature. Priority Three complaints are investigated at the time of the next visit to the facility.

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COMPLAINT FORM CODING

- | FIELD | DESCRIPTION |
|-------|--|
| 1. | <p>Complaint number is constructed with the agency identifier as the first digit. "A" for Aging Services Division, "W" for Welfare Division and "H" for Health Division.</p> <p>The next three digits are sequential numbers for counting complaints. Start a new numerical sequence at the beginning of the state fiscal year. Specific series may be assigned to field offices for tracking purposes. For example 001-499 assigned to LV office, 500-999 assigned to CC office.</p> <p>The last three digits are the type of facility. "SNF for Skilled Nursing Facility, "ICF for Intermediate Care Facility, "AGC" for Adult Group Care, "ADC for Adult Day Care, "HHA" for Home Health Agency, "HOS" for Hospice, "JCA" for JCAHO accredited hospital, "UNL" for unlicensed facilities.</p> |
| 2. | Four digit number supplied by the Health Division. Leave blank for unlicensed facilities. |
| 3. | Priority 1-3 based on Priority System. |
| 4. | Date complaint received. (MM/DD/YY format) |
| 5. | Date complaint investigated. (MM/DD/YY format) |
| 6. | Date complaint closed. (MM/DD/YY format). This is the date that the complaint is forwarded to the Health Division. |
| 7. | Complaint category from Aging Services listing. Code this field <u>after</u> complaint is investigated. Code only the four most important complaint categories in the boxes marked 7a., 7b., 7c., and 7d. |
| 8. | Substantiated. "Y/N/R" answer only. Enter "R" if the complaint was referred to another agency or board with no investigation conducted by the originating agency. Complaints with an "R" in this block should have field "9" blank and an "N" in field "10." |
| 9. | Resolution OK. "Y/N" answer only. |
| 10. | Health Division Follow-up. Does this complaint require Health Division Follow-up? "Y/N" answer only. |
| 11. | This field is used for Health Division cross referencing. |

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CONFIDENTIAL COMPLAINT FORM

Complaint No.

Date _____ T XVIII _____ T XIX _____ T XVIII/XIX _____ OTHER

Complainant _____ Facility

Address _____ Address

Phone _____ Phone

Patient Affected

Nature of Complaint: Priority 1 _____ Priority 2 _____ Priority 3

_____ Complaint Taken By

_____ Investigated By

_____ Date _____ Substantiated? Yes

No

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Supercedes

TN No. N/A

HCFA ID:

Findings

_____ (Attach additional documentation if applicable)

_____ Action

_____ Recommendations

_____ Follow-up Scheduled
Complainant Notified _____ Complaint: _____ A. Scheduled For
Follow-up Date _____ B. Forwarded to Medicare
Date _____ C. Closed Date
_____ D. Other Date

Code

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1. COMPLAINT NUMBER

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2. PROVIDER

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3. PRIORITY

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4. DATE OPENED

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5. DATE INVESTIGATED

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6. DATE CLOSED

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7a. COMPLAINT
CATEGORY

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7b. COMPLAINT
CATEGORY

--	--	--

7c. COMPLAINT
CATEGORY

--	--	--

7d. COMPLAINT
CATEGORY

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8. SUBSTANTIATED

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9. RESOLUTION
OK

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10. H/D
FOLLOW-UP

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11. CROSS REFERENCE

compl1.wcs

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